Central **LHIN**

Creating Caring Communities,
Healthier People... *Together*

An Integrated Health Service Plan for
the Central Local Health Integration Network
2010-2013

Ontario

Central LHIN is working to develop and foster positive relationships with individuals and groups who have a stake in our health care system, to ensure that we keep the "local" in the LHIN. We encourage everyone who lives, works and receives health services in our LHIN to become informed about and get involved in our activities.

We would like to acknowledge the many individuals who contributed to the development of our Integrated Health Service Plan (IHSP) 2010-2013, including our IHSP Steering Committee, our Advisory Networks, and our Citizen's Reference Panel, along with our health service providers, staff and Board of Directors.

Thank you for your time and energy, and your thoughtful and constructive feedback, which was invaluable in shaping our plan to address our local health needs.

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Introduction

Caring communities, healthier people. We all have a role…

Central LHIN is one of 14 Local Health Integration Networks (LHINs) established through the *Local Health System Integration Act, 2006*, by the Ontario government to plan, coordinate, integrate and fund health services at the local level.

Our goal is to improve the health care system: to make it better for all of us who work, live and receive health services in our LHIN. Our success in achieving that goal depends on a number of things. First we need a vision. Then we need a plan. Finally, we need partners who will work with us to ensure our plan makes sense, and who will help us translate our plan into action.

It's been three years since we communicated our vision of Caring Communities: Healthier People, when we launched our first Integrated Health Service Plan (IHSP), and began building relationships with our health service providers, our communities, and our colleagues at the Ministry of Health and Long-Term Care. Now it's time for our LHIN to take a look at what we've accomplished since then, and where we go from here.

Through our first IHSP 2007-2010, working with our health service providers and other stakeholders, our communities enjoyed many system improvements, including: reduced wait times for diagnostic services such as CT scans and MRIs, increased access to surgeries such as cardiac and hip and knee replacements, and the addition of more services, with a particular focus on supports for seniors that help them live independently, for as long as possible. More details on these and other improvements that resulted at the local level from our IHSP 2007-2010 can be found in our yearly Annual Reports.

Moving forward, our IHSP 2010-2013 outlines the four priorities we have chosen – in consultation with hundreds of health care professionals, community leaders and members of the public – to focus on in the next three years:

- Emergency department wait times and the time people spend in hospital beds waiting for alternate levels of care,
- Chronic disease management and prevention,
- Mental health and addictions, and
- Health equity.

This new plan continues to focus on developing the continuum of care within the priority areas for Central LHIN through building on achievements from our first IHSP, and focusing our efforts on areas where we can make a positive impact. It also supports the priorities of the Ministry of Health and Long-Term Care, in order to link provincial resources to local needs.

IHSP 2007-2010

- Improving services for seniors
- Mental health and addictions
- Neurological health services
- Chronic disease management and prevention
- Wait times
- Emergency department services
- Cancer care

IHSP 2010-2013

- Emergency department /alternate level of care
- Chronic disease management and prevention
- Mental health and addictions
- Health equity

Working together to develop a new IHSP

In 2008, Central LHIN initiated a Health Service Needs Assessment and Gap Analysis (SNAGA) project to give us a better understanding of health care challenges and opportunities in our LHIN, including the specific concerns of our Aboriginal and French-language communities. Two components shaped the findings of the final SNAGA report: statistical data about our LHIN, such as the average age, gender, and health of our population, and input from our stakeholders through an advisory committee, interviews with senior health professionals, focus groups and public consultation sessions.

When considered alongside the provincial priorities and the outcomes of our first IHSP, and always with a focus on equity and quality, the information we learned from SNAGA was important as we developed our next IHSP. It helped give us a clear picture of where our efforts were addressing some of the gaps in our local health system, and where we weren't quite on the right track. It helped us agree on our four priorities.

For Central LHIN, the high level planning process looked as illustrated above.

From plan to action

Choosing priorities is challenging because it means making tough decisions about what areas of the health system we will focus on over the next three years. Consulting with our health service providers and the people in our communities to collectively check our thinking helps us ensure we have selected priorities that we all believe have potential for the greatest positive impacts on our health system.

Guided by a steering committee made up of representatives from across our service provider sectors, the stakeholder engagement stage shown in the planning process illustration involved a series of activities including discussions with physicians and the aboriginal and francophone communities. We shared drafts of our report with the board chairs and senior leaders of our health service providers. We also hosted three Citizens Reference Panels to both educate and to obtain feedback from the public on our plan.

Aside from validating our priorities, these activities helped us better understand the perspectives of those who provide health services in our communities, and the people who receive those services. These are important insights to have as we work to set clear, realistic, measurable outcomes for each of our priorities.

Over the next three years, we will collaborate with our stakeholders to develop and implement our Annual Service Plans, which spell out in greater detail the specific things we will do each year to accomplish the goals of our IHSP. We will review progress in relation to our IHSP on a regular basis, and continue to engage with our partners so we can be certain our plan remains aligned and responsive to local needs.

We will also look for opportunities for all of us to contribute to creating an efficient, high-quality system in which services are available to us when and where we need them, and in which we make the best use of the resources we have. The kind of health care system we all want for ourselves and the people we care about.

To learn more how our IHSP 2007-2010 has made a difference in our communities, and to follow the progress of our IHSP 2010-2013, visit our website at www.centrallhin.on.ca

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The Provincial Strategic Plan and Priorities

How our IHSP 2010-2013 aligns with Ministry priorities...

As partners in planning for the necessary improvements to health care in Ontario, both LHINs and the Ministry of Health and Long-Term Care play an important role. The Ministry of Health and Long-Term Care sets and shares its strategic vision and priorities. Within their IHSPs, the LHINs align with the Ministry's strategic directions, while at the same time setting additional priorities that make sense at the local level.

Like other LHINs, Central LHIN's IHSP 2010-2013 supports the Ministry of Health and Long-Term Care's priorities to promote equitable access to health and health care for all Ontarians, and improve access to care in three areas:

- Reducing wait times in emergency departments
- Reducing the time people spend in acute care beds in hospitals waiting for alternate levels of care
- Supporting the roll-out of Ontario's Diabetes Strategy

The Ministry has also identified mental health and addictions, and eHealth as key focus areas, both of which we currently support through our strategic priorities and activities.

Reducing Emergency Department Wait Times

Ontarians are entitled to safe, reliable, appropriate and high-quality care when they visit an emergency department. Timely access to care can significantly improve a patient's experience, which is why reducing emergency department wait times is one of the Ontario Government's top health care priorities.

Experience tells us that a backlog in one area of the health system can result in delays in many other areas. To achieve shorter emergency department wait times, LHINs need to improve the efficiency of care delivery across the entire health system. We also know that patients with non-urgent or less urgent needs account for about half of all emergency department visits, so we need to look at ways to build care capacity within the community so people can access appropriate care outside emergency departments.

Under the Ministry's direction, LHINs are working to meet provincial targets, and publicly report our emergency department wait times.

Reducing Time in Acute Beds Waiting for Alternate Levels of Care

When patients complete the acute care phase of their treatment in hospital, they often remain in acute care beds while they wait to be discharged or transferred. They need an "alternate level of care" – but none is available.

Currently, close to 19% of patients currently in Ontario hospital beds are waiting for an alternate level of care opening, such as a long-term care or rehabilitation care bed. This often leads to longer wait times in the emergency department as patients wait in that department to be admitted to a bed in the hospital.

The LHINs are working with our health service providers and the Ontario government on a variety of initiatives that will help patients get the care they need – whether that's in a hospital, in a long-term care or rehabilitation care facility, in the community or at home.

Supporting Ontario's Diabetes Strategy

Ontario's diabetes strategy will help tackle a growing – and expensive – health care challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population). This number has increased by 69% over the last 10 years, and is projected to grow to 1.2 million by 2010. Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion each year.

The provincial diabetes strategy will improve access to prevention programs and team-based care. The strategy includes an online diabetes registry, which is an electronic information, diagnostic, and educational tool that will enable health care providers to monitor patients living with diabetes. The registry will include best practice guidelines, alerting clinicians of the need

for recurring diagnostic tests, and will give patients access to information and educational tools to help them better manage their diabetes.

The LHINs are committed to improving access to diabetes care by supporting the roll-out of the provincial Diabetes Strategy.

Enhancing Mental Health and Addictions Services

According to the Ministry of Health and Long-Term Care's discussion paper *Every Door is the Right Door*, about one in five Ontarians will experience a serious mental illness or harmful substance use at some time in their lives. This issue affects people of all ages, and the cost of preventing and treating mental illnesses and addictions is only a fraction of what these illnesses cost society in lost productivity and other social costs. In fact, investing in actively supporting people to stay mentally healthy saves money. Every $1 spent on mental health and addictions treatment and services saves $7 in health costs and $30 in lost productivity and social costs.

The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. For the first time, the province's strategy looks beyond health to include mental health and addictions services funded by other provincial ministries.

The LHINs will support the rollout of the provincial mental health and addictions strategy, helping to create a system that provides everyone who needs care with equitable access to safe, respectful and effective services.

Building on an eHealth Framework

eHealth is a key enabler for achieving the Ministry's priorities and those of the LHINs and their partners. In March 2009, the Ontario government released a provincial three-year eHealth strategy, which focuses on three clinical priorities: diabetes management, medication management, and wait times. These information technology investments will provide secure access to clinical information and support the delivery of high quality health care to patients across the province. The provincial eHealth strategy can be viewed at www.ehealthontario.on.ca

Imagine: A Healthier Ontario

The Ontario Government's strategic directions helped to shape this IHSP. By aligning local initiatives with provincial priorities, we can provide appropriate, coordinated, safe and efficient health services. We can also achieve our common goal of Healthier People, Healthier Communities and a Healthier System for All.

Find out more about the Ontario Ministry of Health and Long-Term Care at www.health.gov.on.ca

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Central LHIN's Vision for Our Local Health System

What we can accomplish together...

Through our IHSP 2010-2013, Central LHIN remains committed to achieving our vision of caring communities, healthier people, by supporting a health care system that is there for our residents when they need it, now and in the future.

This vision was first articulated in our Strategic Plan and supported by our IHSP 2007-2010. The Strategic Plan is a visual depiction of Central LHIN's mission, vision and core values.

To us, a caring community is one that is truly engaged, where each of us – from our staff and Board of Directors to our health service providers and our residents – view ourselves as important contributors in working together to create a common vision for our health care system.

The IHSP 2010-2013 is our shared roadmap – a way to help all of us understand our goals and what steps we must take *together* to get to where we want to go.

Central LHIN Strategic Plan
Vision
Caring Communities- Healthier People
Mission
Enable Access to an Integrated Health System for our Communities
Core Values – Making a Difference
• Collaboration/Partnership • System Responsiveness and Quality
• People/Community Focused • Openness and Transparency
Strategic Directions
Strategic Priorities
Creating a Caring Collaborative Environment
Service Provider Relationship Development
Building Community Confidence
Community Engagement
Establishing Local Health System Priorities
Integrated Health Service Plan Implementation
Facilitating Design of a Continuum of Care and Support
Coordination and Integration
Developing Central LHIN's Capacity to Deliver its Mission
Central LHIN Development
Enablers
• Information Technology/Information Management • Heath Human Resources
• Primary Care • Strategic Investment • Integration
The Ontario LHIN Mandate:
Be responsible for planning, coordinating, integrating and funding local health services

In fact, our ability to reach our vision depends on creating new levels of innovative partnerships with our health service providers as well as organizations and individuals outside of health care.

With the assistance of the Faculty of Health at York University, we identified four capability areas that impact system level change. These areas are:

- Integration, Coordination and Information Access – health service providers partner and collaborate to reduce inefficiencies and provide seamless care,
- Services – people have access to the services they need, when they need them,
- Adaptability – the system is responsive to continually changing local needs and growth pressures and performance is monitored to identify opportunities for improvements, and
- Sustainability – services are cost effective, the system accounts for and manages rising demand for capacity and makes the most of available resources.

A focus on these capabilities areas during planning will ensure we are working to create positive change on a system level – together – to move us closer to our vision of caring communities, healthier people and health system sustainability over the next three years.

Central LHIN is charged with transforming the system through consultation and feedback amongst stakeholders. What concrete steps can we take together to get to where we want to go?

4

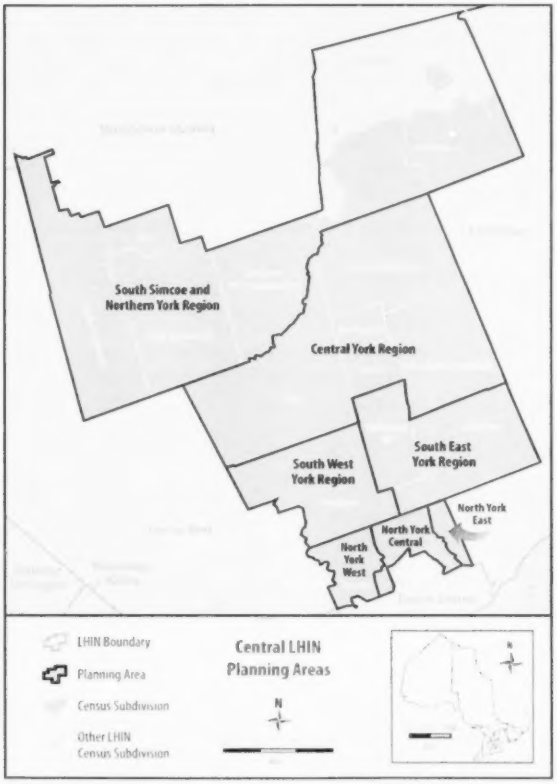
Overview of Central LHIN's Current Local Health Care System

A snapshot of our local health system...

Having an in-depth understanding of the people living within Central LHIN, their health status and the health services currently available helps us to identify priorities, allocate resources effectively and make plans for the future.

As one way to aid in our planning at a local level, Central LHIN has divided its geography into seven planning areas. In much the same way as LHIN boundaries are for administrative purposes only, our planning areas represent no barrier to receiving services in any part of our LHIN.

Each planning area has varying populations, age structures, economic conditions, health and social characteristics, allowing us to target very specific local issues with our plans.



Who lives in Central LHIN?

With 1.6 million residents (which is 13% of Ontario's total population), and a high population growth rate of 13.7 % over the next ten years, Central LHIN is both the most populous and one of the fastest growing LHIN, in Ontario.

We will also experience greater-than-average population aging over the next 10 years, with the 65+ age category projected to grow from 204,139 to 285,555. That's an additional 81,416 seniors, or a 40% increase. In comparison, the whole province projects a 33% increase in the number of seniors aged 65+ over that same period.

These issues pose challenges for our health service providers as they work to meet the ever-growing demand for care and services.

Central LHIN has a very diverse geography and population. Our boundaries include the northern section of the City of Toronto, a large portion of York Region, and the southern part of Simcoe County. We are spread over 15 census subdivisions, four of which are shared with other Ontario LHINS, including Toronto Central, Central West and North Simcoe Muskoka. This means we provide care to many people who live outside our LHIN, and other LHINs provide care to many of our residents.

Approximately 70% of our population lives in North Toronto, Vaughan, Richmond Hill and Markham. More than 25% of the population lives in South East York Region. Although our LHIN is primarily urban, it has a significant rural region in the north, which can represent challenges to residents when accessing services.

The population of Central LHIN is very diverse. We have a relatively small presence of Aboriginal/First Nations within our LHIN, and the highest proportion of immigrants in the province, almost twice the provincial average of visible minorities and hence a higher percentage – compared to the province – of people whose mother tongue is not French or English.

In the summer of 2009, a new, more inclusive definition of Francophone was adopted by the province. As a

Central LHIN Population Factors by Planning Area	Ontario	Central LHIN	South Simcoe and Northern York Region	Central York Region	South East York Region	South West York Region	North York West Region	North York Central Region	North York East Region
Total Population 2008	12,986,332	1,651,681	113,257	204,207	465,683	230,536	237,884	276,973	123,141
% of LHIN Population in Planning Area			7%	12%	28%	14%	14%	17%	7%
% Population Aged 65+	14%	13%	11%	11%	10%	9%	15%	17%	14%
% Population Visible Minority	23%	42%	5%	9%	52%	23%	50%	38%	56%
% Population Immigrants	23%	48%	14%	21%	54%	45%	59%	56%	63%
% Population Francophone	4%	1%	1%	2%	1%	1%	1%	1%	1%
% Population Aboriginal	2.0%	0.4%	1.4%	0.8%	0.4%	0.1%	0.4%	0.2%	0.2%
% Population English Mother Tongue	68%	50%	88%	84%	42%	48%	43%	46%	42%
% Low Income Families	11%	9%	7%	5%	5%	4%	20%	13%	15%
% Single Parent Families	15%	15%	13%	12%	12%	10%	27%	17%	19%
% Population Aged 20+ with less than High School Education	25%	22%	28%	17%	19%	23%	39%	18%	18%

Source: KPMG Central LHIN Health Service Needs Assessment and Gap Analysis 2008

result, Francophones are now defined as including those whose mother tongue is neither French or English but who speak French at home or who come from a place where French is an official language. This change in the definition potentially increases the current proportion of Francophones in our LHIN from approximately 1% to approximately 3.2%.

Overall, North Toronto, Markham and Vaughan are the areas where we face the greatest challenges providing culturally and linguistically appropriate services for diverse communities.

Because Central LHIN's planning areas are so different, each has their own unique challenges and needs that must be considered when planning at a system level. Our *Population Factors by Planning Area* table illustrates some key population factors for each planning area.

The health of our population

Examining Central LHIN's health profile helps us work towards our priority goal of reducing health disparities and ensuring equitable access to health care in our LHIN by identifying populations that would benefit from focused initiatives.

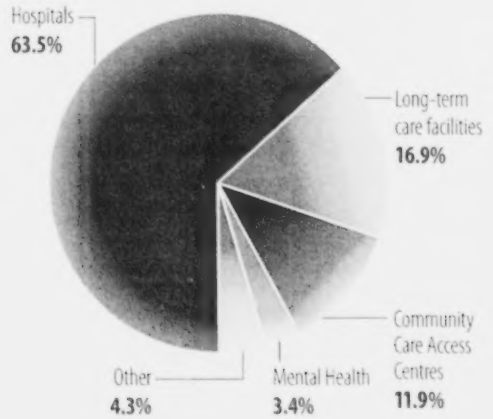
Generally, our residents have a lower incidence of chronic diseases and conditions such as high blood pressure, diabetes, heart disease, arthritis and asthma than that of Ontario as a whole. However, social determinants of health, such as unemployment, education levels and risk behaviours such as smoking and obesity, have all been shown to affect how healthy people are. Within our planning areas there are variations in health status due to the differences in these characteristics.

According to the Canadian Institute of Health Research, high risk populations are groups of people that share characteristics – such as homelessness, single women living in poverty or lone-parent families – associated with high risk of adverse health outcomes. Two of our planning areas – South Simcoe / Northern York Region and North York West – have been identified as high risk populations from a population health standpoint. A higher number of the residents in these two planning areas face serious chronic diseases, as well as obstacles to accessing primary care, compared to other planning areas in the LHIN.

These two planning areas will be the focus of targeted initiatives through our health equity priority, outlined in detail in chapters six to eight.

As the population ages, more LHIN residents will develop chronic diseases and will experience greater health service needs. Chronic disease conditions place a high burden on the health care system and reduce quality of life. As such, Central LHIN has selected chronic disease management and prevention as a planning priority to support the province's diabetes strategy, and where possible will also leverage new resources and initiatives to address other chronic diseases.

2008-2009 Health Sector Budget as a percentage of Central LHIN total budget



With seniors as the fastest growing age group in our LHIN – the 65-74 age category is expected to grow by 56%, the 75-84 age category by 13%, and the 85 and older age category by 43% – the growing health care needs of our aging population will significantly impact Central LHIN over the next five to 10 years and beyond, a challenge we have identified within each of our priority areas.

The health service providers in our LHIN

The mandate of the LHIN is defined by the *Local Health System Integration Act, 2006*, which also describes which agencies fall under the LHIN's mandate. A key role for our LHIN is to facilitate integration within the health system. We do this in part by actively encouraging our health service providers to look outside their walls and seek opportunities to collaborate and partner with other health service providers.

Central LHIN has 98 health service providers delivering a range of programs and services across the continuum of care. Some of our providers operate facilities within multiple sectors. The breakdown is as follows:

- seven public and three private hospitals
- forty-six long-term care homes
- thirty-five community support service providers
- twenty-four mental health and addictions service providers
- one community care access centre
- two community health centres

Many Ministry of Health and Long-Term Care-funded services do not fall under our mandate as defined by the *Local Health System Integration Act, 2006*, including:

- most physician services,
- drug benefits,
- independent health facilities,
- laboratories,
- ambulance services, and
- public health.

A complete listing of our health service providers is available on our website at www.centrallhin.on.ca.

Our health service provider budget

For 2009-2010, Central LHIN's budget is $1.6 billion, to allocate across a range of health programs, delivered by our 98 health service providers. Hospitals account for the majority of spending, at 63.5% or a little over $1.0 billion.

Our residents represent 13% of Ontario's population. However, in 2008-2009 the budget for our health service programs was only 7.62% of provincial health program expenditures. Central LHIN receives less funding per capita than the provincial average within most of our health service provider sectors.

Over time, we expect that collaboration among neighbouring LHINs will continue to help us align available health services and resources to improve efficiencies through information sharing and joint planning.

Differences such as ethnicity, income, education, language, gender and age can lead to health disparities across our planning areas. That's why health equity is a Central LHIN priority.

5

Framework for Planning

The information that shapes our planning decisions...

Central LHIN's mandate is to plan, fund, coordinate and integrate health care services at the local level. That means being responsible for funding local health service providers and putting local health dollars where they are most needed based on community priorities. It also means using strategic and evidence-based decision-making tools to guide our short- and long-term planning, and incorporating data from a variety of qualitative and quantitative sources.

Our IHSP 2010-2013 will guide us over the next three years, and will come to life within the context of the planning frameworks described below.

Mapping our Strategy

With our capability areas – described in chapter three – illustrating our vision for the health system – or where we want to be – our strategy map shows how we're going to get there. The strategy map links the IHSP 2010-2013 priorities to our capability areas. It shows how each part of our plan to advance our priorities is dependent on a number of other factors, including our core values, our internal planning processes, and the groups or individuals and processes (we call them enablers) that we rely on to help us achieve our goals and reach our vision.

Central LHIN IHSP 2010-2013 Strategy Map

And move towards our vision & mission
Caring Communities, Healthier People, Enable Access to an Integrated System for Our Communities
We will improve our CAPABILITIES
Integration
Coordinated services
Available information
Partnerships & Collaborations
Service
Service delivery & capacity
Access to services
Breadth of services
Effectiveness of services
Adaptability
Capacity for system change
Continuous improvement
Ability to respond to growing pressure
Sustainability
Resource & productivity maximization
Focusing our energies on provincial & local planning PRIORITIES
Reduce ED Wait Times
Reduce % ALC
South Simcoe/ Northern York Region Planning Area
North York West Planning Area
Chronic Disease
Mental Illness and Addictions
And transform & improve services through our PROCESSES along the entire continuum of care for all ages
Planning
Use evidence to achieve highest quality interventions & impact
Integration
Improve access & increase efficiencies
Resource Allocation
Funding allocated based on population health needs & priorities
Performance Management
Monitor performance through accountability agreements & system measures
Community Engagement
Facilitate dialogue & action
We will work together with the help of ENABLERS
Primary Care
eHealth
Human Health Resources
Decision Support Services
Our VALUES: Collaboration/Partnership, System Responsiveness & Quality, People/Community-Focused, Openness & Transparency
To provide QUALITY services namely: accessible, effective, safe, patient-centered, equitable, efficient, and appropriately resourced

Using a Systematic Approach to Identify Priorities

To identify our IHSP 2010-2013 planning priorities, Central LHIN and its stakeholders used a systematic process based on local evidence and data, and criteria that helped us rank potential priorities.

Embedding Quality in Our Planning

Central LHIN is committed to working together with our health service providers, stakeholders and the Ministry of Health and Long-Term Care to ensure that the residents of Central LHIN have access to quality health care.

The Ontario Health Quality Council's attributes of a high-performing health system are embedded within Central LHIN's capability areas and planning priorities and will guide the development of future quality measures at the system level. Here's how we incorporate the attributes into our planning:

1. **Integrated:** Integration is one of our key strategic outcomes and inherent in the role of our LHIN. We will continue to look to integration to ensure that patients experience a seamless continuum of care and to improve system efficiencies.
2. **Patient Centered:** We will promote patient- and family-centered care and culturally appropriate programs.
3. **Accessible:** We will continue to support the right care, at the right time, in the right place, and expand programs in underserviced areas to strive for equitable access.
4. **Appropriately Resourced:** We will support evidence-based, best practice programs. Criteria for funding approvals will include a focus on sustainability and cost effectiveness.
5. **Effective/Efficient:** We will look to leverage our health service provider accountability agreements to achieve the best possible results. We will make sure that new funded projects and services have a rigorous evaluation component to ensure they improve the overall quality of the system, the patient experience and health outcomes.
6. **Equitable:** We will consider our health equity priority in all our planning decisions and analyze the potential impact of program or policy changes on health disparities and/or health disadvantaged populations. We will work with our providers to create robust health service provider-specific equity programs.
7. **Safe:** We will participate in and foster quality improvement and risk management programs that are geared towards ensuring safe health care within our region. We will participate and collaborate with other LHINs to implement and evaluate a population based quality program.
8. **Population Based:** Our plans and strategies are based on our current and projected demographics and focus on improving population health. We will focus on our Francophone and Aboriginal populations through targeted engagement to identify needs and promote culturally appropriate programs and services.

In addition, as part of our commitment to quality, Central LHIN will continue to collaborate with other LHINs to measure, monitor and improve system quality. Specifically we will work together to implement a shared quality framework called Triple Aim, which focuses on population health.

Enablers

Central LHIN has identified four enablers within our IHSP 2010-2013 – forces and resources that impact on the success of our projects and programs – that will play a key role in achieving our goals.

Health Human Resources

Aging, growing and diversifying populations all have a dramatic impact on both the demands for health services and the health sector workforce. Over the next three years, Central LHIN will need to forge partnerships with health service providers, provincial human resource planning bodies, and educational and training institutions to build our capacity to deliver services and explore opportunities to share health human resources.

In 2008, Central LHIN conducted an environmental assessment of our health human resources which has given us an understanding of the health human resource needs, within our LHIN. We will consider the following in our planning:

- available benchmark health human resource data with respect to the needs of our LHIN,
- results of health service provider surveys, and
- learnings from health human resource stakeholder forums.

Primary Care

Family physicians and other primary care providers are the front line of the health system, caring for people and helping them navigate the system. They provide clinical services as close to home as possible, access to other services, and they contribute to continuity of care. Central LHIN is already engaging our primary health care providers to create avenues that support dialogue through ongoing meetings and advisory groups.

We will continue to collaborate to leverage resources, programs and services to enhance primary care especially in planning areas where inadequate access has been identified as an issue. Other actions include:

- ongoing dialogue with medical staff,
- LHIN workshops, and
- developing a primary care engagement strategy to provide for ongoing input into our priorities and strategies.

Decision Support

Central LHIN has created a Decision Support Advisory Group to support our work groups in system planning, evaluation and performance measurement from an information/data perspective and to seek opportunities for collaboration on decision support activities among all health service providers in Central LHIN.

This group will continue to leverage this resource to:

- advise on interpretation of information/data, and tools for consistent data collection where standardized data is not available (e.g. surveys, service inventories, etc.),
- advise on indicators relevant to monitoring IHSP goals, outcomes and strategies,
- advise on benchmarks or comparators available for performance monitoring, and
- identify opportunities and a plan for collaboration on decision support activities to improve efficiencies, quality and access of information among LHIN providers.

eHealth

Whether it is information to understand and address a client's needs (i.e. hospital discharge summaries or diagnostic results), or data that describes services available in a particular region, health services are information-dependent. Due to the recognition of the strong referral relationship of consumers between our two LHINs, and similarities in local health priorities, Central LHIN collaborates and partners with the Toronto Central LHIN on eHealth planning and implementation. Together we've developed a joint eHealth strategy, based on the Ministry strategy and the local priorities of the LHIN.

This joint eHealth strategy includes:

- improve the care process through initiatives such as Resource Matching and Referral,
- improve the exchange of information across the health system through initiatives like Connecting GTA (formerly Health Integration Access Layer and Provider Portal),
- support patient/client participation in their own health care using technology such as the patient portal, and
- support provincial eHealth initiatives such as the Diabetes Registry, Ontario Lab Information System, Drug Information System and the Wait Time Information System.

Our eHealth Action Plan is included as an appendix of this IHSP 2010-2013 document.

Managing Risk

As planners, we try to manage risk by determining ahead of time any issues that could negatively impact our plans or stop us from achieving our goals. Central LHIN has identified a number of issues that could affect our success in reaching the goals of our IHSP 2010-2013 planning priorities. Here is some detail on these risks and how we plan to address them:

Health Human Resources: the ability to recruit and retain appropriate health human resources will continue to be a challenge over the next three years. According to our Health Human Resources Risk Reduction Plan Final Report, 2008, an aging workforce will also pose a challenge as approximately half of all employees in Central LHIN are above the age of 45.

How we will address the risk: continue to look for ways to integrate services to reduce gaps and improve linkages amongst health service providers, and explore opportunities to create additional capacity.

Capacity: the ability of our health service providers to meet demand for services will directly impact how effectively we can address service gaps.

How we will address the risk: continue to work with stakeholders to identify opportunities to improve use of existing health care services and linkages amongst health service providers to benefit the community.

Financial Constraints: our priorities are aligned with those of the Ministry of Health and Long-Term Care, which – just as we do at the local level – must balance competing priorities. Like other organizations across the sectors, Central LHIN operates in an environment of financial restraint, where we must make the best use of limited financial resources. In the Central LHIN multi-year financial plan, no new dedicated funding is identified for chronic disease management, mental health and addictions or health equity initiatives. This can impact decisions on future one-time and yearly funding allocations, and impede our ability to develop or continue priority projects.

How we will address the risk:

- create collaborative partnerships both internally and externally to ensure we identify and take advantage of all possible funding opportunities,
- use measurable targets help to establish the extent to which program objectives are achieved and monitor programs, services, and performance indicators to ensure compliance with performance agreements, and
- collaborate with health service providers to review base programs as a means to identify opportunities for integration and to make services more efficient.

Stakeholder Opposition: change – even when it's good for us – is not easy. Sometimes our plans encounter resistance from those who have an interest in our actions, either because they are providers or consumers of health care services in our LHIN.

How we will address the risk: remain committed to engaging with our stakeholders to ensure we listen to their concerns, incorporate their input into our priorities, address inequities and garner support for our plans at the earliest stages possible in our timelines.

Working Together

All the planning in the world can only take our organization so far. For true and lasting system changes to occur, it will take collaboration by organizations, communities and individuals across and beyond our LHIN. Working with all partners who play an integral role in health care including those who do not report directly to the LHIN (e.g. public health, physicians and municipalities, etc.) will be key.

To support planning initiatives and identify integration opportunities, Central LHIN will continue to rely on its range of Steering Committees, Advisory Groups, Committees and Work Groups to advance the priority areas identified in the IHSP.

Over the next three years, the health service accountability agreements that Central LHIN has negotiated with its health service providers will also help focus planning around aligning available resources to the priorities outlined in our IHSP, and establish a solid foundation for the sustainability of our health care system.

Central LHIN's strategy map shows how our core values, internal processes, planning priorities, and enablers are interconnected and all play a role in helping us to achieve our goals and reach our vision.

6

Local Health System Priorities and Strategic Directions

A look at our four planning priorities...

Central LHIN's IHSP 2010-2013 will focus on four planning priorities that align with Ministry of Health and Long-Term Care priorities, and that will help us address the areas of greatest need across our seven planning areas. This table gives an overview of some of the challenges that currently exist in each priority area, and some detail on where we envision improvements.

Central LHIN IHSP 2010-2013 Planning Priorities • Current and Future State

Priority	Where we are (current state)	Where we want to go (future state)
Emergency Department and Alternate Level of Care	• Long wait times for patients • Ministry of Health and Long-Term Care priority for improvement	• Reduced numbers of non urgent cases presenting in emergency departments • Improved triage and admission processes • Improved access to hospital services • Improved access, coordination and integration of services
Chronic Disease Management and Prevention	• Health system designed for acute care • Chronic disease associated with high costs • Aging population leading to higher demand	• Improved partnerships leading to increased access to services • Enhanced continuity of care and improved system processes • Prevention strategies to delay onset and reduce progression of disease • Skills and supports focused on self management for patients and families
Mental Health and Addictions	• Long wait times for patients • People in need not receiving mental health and addictions services • Gaps in services	• Improved linkages among health service providers • Reduced non urgent emergency department visits • Programs to address service gaps
Health Equity	• Variations in health status and access to care • Certain communities in Central LHIN are at greater risk of chronic disease	• More equitable access to health care in all Central LHIN communities • Increased outreach and community engagement to target populations

In the next few pages, we will outline our strategy and goals within each of these priorities. More information is also available in the *At a Glance* tables found in the appendices of this IHSP document.

Priority: Emergency Department and Alternate Level of Care

Reducing the time people spend in the emergency department waiting for care is a complex issue that has become both a provincial health care priority, and a Central LHIN planning priority.

Because moving people through the emergency department depends in part on a hospital's ability to either admit patients to its acute care beds, or to discharge patients to appropriate destinations (for example, other care settings or home in the community with home care), reducing wait times is an issue that can't be solved by focusing on the emergency department alone.

Central LHIN's emergency department and alternate level of care strategy aligns to the Ministry of Health and Long-Term Care's emergency department and alternate level of care strategy and recognizes that improvements across the system are necessary to ensure people receive prompt emergency care and that appropriate alternatives to hospital care exist in the community.

Our Emergency Department and Alternate Level of Care Strategy

GOALS

What we want to do

- **Reduce demand on emergency department services**
- **Increase capacity and improve emergency department performance**
- **Reduce length of stay in alternate level of care beds to improve access to hospital services**

ACTIONS

How we're going to do it

- Explore opportunities to better manage disease groups to reduce emergency department demand
- Improve emergency department performance
- Improve discharge planning
- Improve linkages to community and primary care
- Expand implementation of integrated care models
- Expand access to rehabilitation and outpatient services
- Enhance transitional care options and services
- Develop and enhance interventions to prevent emergency department visits
- Implement applicable eHealth strategies
- Focus Aging at Home investments to address these goals

OBJECTIVES

What it could look like

Over the next one to two years...

- Reduce emergency department visits by targeted groups
- Reduce unplanned re-admission rate to emergency departments
- Reduce emergency department wait times and achieve targets identified for admitted patients, non admitted high acuity patients and non admitted low acuity patients
- Reduce alternate level of care days in hospital
- Monitor baseline data on patient satisfaction
- Reduce delays in placement to appropriate level of care and settings

Over the next three years...

- Maintain a reduction in time spent in the emergency department and alternate level of care days
- Reduce delays in placement to appropriate level of care and settings

Some inspiration from the perspective of our IHSP 2010-2013 Citizen's Panel. What could be...

Jack, a nine year old recent immigrant who lives in the Markham area with his single mother, is brought into the emergency department late one night because he is sick to his stomach and running a high fever. Jack and his mother are promptly greeted by a nurse practitioner who records Jack's case history and addresses his immediate care needs. Although a Chinese translator is not available, the nurse practitioner is able to access Jack's medical history through the hospital's electronic health records and information system. Jack sees a doctor within 15 minutes of arriving at the hospital and is diagnosed with the flu. Meanwhile, the nurse practitioner makes a note to have a clinician who speaks Chinese contact Jack's mother in the morning to ensure his health has improved. The translator arrives and his mother is given detailed instructions on how to best care for Jack when they get home.

Priority: Chronic Disease Management and Prevention

Chronic diseases, such as diabetes, arthritis and cardiovascular disease, have significant personal, social and economic impacts. In addition, the treatment of chronic diseases and their complications place significant demand on our acute care system and community-based services.

Central LHIN's chronic disease management and prevention strategy focuses on streamlining the delivery system and putting a plan in place to support self-management. It aligns with the Ministry of Health and Long-Term Care's Chronic Disease Prevention and Management Framework, and will help us to work towards improving health outcomes, contributing to the provincial effort to minimize wait times and reducing the costs associated with treating chronic diseases.

Our Chronic Disease Management and Prevention Strategy

GOALS

What we want to do

- **Support MOHLTC rollout of the Ontario Diabetes Strategy**
- **Collaborate with the Ontario Renal Network**
- **Enhance self management supports for chronic disease**
- **Improve primary and secondary prevention of chronic disease**

ACTIONS

How we're going to do it

- Work with the Ontario Renal Network to establish a LHIN-wide renal program
- Participate in the implementation of the Ontario Diabetes Strategy
- Participate in the implementation of eHealth strategies associated with chronic disease management
- Support the develop and implementation of multidisciplinary clinical pathways /incorporate self management
- Promote working relationships with family health teams and other primary care providers
- Maintain an inventory of self management practices
- Improve self management supports and programs for high risk groups
- Promote self management training for professionals and peers
- Educate health care professionals on their role in self management
- Identify and share the adoption of best practices for prevention of chronic disease
- Collaboratively implement prevention activities across the continuum
- Improve continuity of care through better integration of services across the continuum

OBJECTIVES

What it could look like

Over the next one to two years...

- Support the implementation of local activities of the diabetes strategy as per MOHLTC
- Enhance access to dialysis services through collaboration with the Ontario Renal Network
- Support the work of the Chronic Disease Management and Prevention Advisory Network to identify and disseminate best practices in primary/secondary prevention services

Over the next three years...

- Reduce avoidable emergency department visits for chronic diseases
- Reduce unplanned readmissions for targeted populations

Some inspiration from the perspective of our IHSP 2010-2013 Citizen's Panel. What could be...

Sam, healthy all his life except for a mild heart murmur identified years ago, worked in government, raised a family and traveled often. Shortly after retirement, while on a trip, Sam finds he can't keep up with his wife. Back home, his family doctor identifies that the murmur has developed into a blocked artery, putting him at risk of a heart attack. Sam is referred to a cardiologist in Newmarket, who recommends immediate surgery, which takes place a week later. At Sam's post-surgery check up, his cardiologist provides important advice on how to manage his condition. Seven years later, Sam credits his determination to learn all he could about managing his illness and leading a healthy lifestyle, along with the talent of his health care team for returning his heart condition to where it belongs, the farthest from his mind.

Priority: Mental Health and Addictions

For a variety of reasons, people with mental health and addictions challenges do not always receive the health care they need. For example, data suggests more than 100,000 individuals in Central LHIN face substance abuse issues, however in 2007-2008, just over 3800 people received addiction treatment.

By continuing to make mental health and addictions a priority in Central LHIN, we can focus resources where they make the biggest difference – coordinating care and bridging gaps in the system, reducing wait times for assessment and services, and enhancing community supports to reduce the burden of mental health and addictions on emergency departments and alternate level of care beds in hospitals.

Our mental health and addictions strategy aligns with the Ministry of Health and Long-Term Care's model for mental health and addictions service delivery.

Our Mental Health and Addictions Strategy

GOALS
What we want to do

- **Support the MOHLTC's Mental Health and Addictions Strategy**
- **Reduce gaps in service and improve linkages across the continuum of care**
- **Target mental health and addictions needs that impact access to emergency department and hospital services**
- **Promote awareness of diversity needs**
- **Improve data quality and analysis in the mental health and addictions sector**

ACTIONS
How we're going to do it

Support the implementation of local activities as per the MOHLTC Mental Health and Addictions Strategy

- Develop community alternatives
- Strengthen family supports, particularly in high need populations
- Increase collaboration across health, community sectors and neighboring LHINs
- Build connections with primary health care and chronic disease management prevention strategies
- Develop community supports to divert people from emergency departments, and decrease acute care pressures
- Improve engagement with those with lived experiences and families
- Improve access to culturally and linguistically competent services
- Improve data capture and monitoring
- Identify high risk populations based on emergency department and alternate level of care data

OBJECTIVES
What it could look like

Over the next one to two years...

- Implement local activities as per the MOHLTC Mental Health and Addictions Strategy
- Expand community based mental health services as alternatives to the emergency department

Over the next three years...

- Support initiatives that streamline access to care
- Improve access to supportive housing and related services
- Improve understanding of current state and challenges facing data quality within the sector

Some inspiration from the perspective of our IHSP 2010-2013 Citizen's Panel. What could be...

Jill attends a seminar at work on depression, where she picks up a few resources for her husband Bill, who has lately seemed disinterested in life. Bill is frequently withdrawn from family and friends and has missed a great deal of work. Jill calls a centralized health access number to find out about care options in her community. She talks to a local mental health services provider about how to support Bill in accessing help. Within 24 hours, a nurse – who specializes in working with individuals with mental health issues – comes to the couple's home to do an initial assessment. With her and Jill's encouragement, Bill agrees to make an appointment for a comprehensive assessment.

Priority: Health Equity

In general, Canada is a prosperous country with a healthy population. However, not all Canadians are equally healthy. Inequity in health care relates to social inequality and disadvantage, and results in differences in health outcomes that are unfair and avoidable.

Central LHIN's health equity priority aims to reduce avoidable health disparities within targeted population groups in the South Simcoe/Northern York Region and North York West planning areas. Both of these areas have been identified as having high risk populations because of higher than average incidence of serious health conditions such as hypertension, heart disease and diabetes, and inadequate access to primary care.

In South Simcoe/Northern York Region there is a high rate of emergency department use because of the shortage of family physicians, walk-in clinics and community services to treat non-urgent cases. Overall there are limited services available in this planning area, so we will work with our health service providers and these communities to expand services where possible.

Our Health Equity Strategy

GOALS

What we want to do

- **Target investments in health care services in identified geographic areas to address health service inequities**
- **Improve access to diabetes care and primary care in these areas**
- **Engage the public and improve collaboration across sectors**
- **Identify and support Aboriginal engagement strategy**
- **Support French Language Services engagement strategy**
- **Monitor the health status indicators in the identified geographic areas**

ACTIONS

How we're going to do it

- Engage target populations to identify health priorities and plan services
- Improve primary care access in the planning areas
- Create collaborations and partnerships
- Strengthen community service capacity to reduce reliance on acute care sector and to promote prevention
- Evaluate cross sectoral service models for implementation
- Incorporate uniqueness of rural/urban health care settings into planning
- Direct increased efforts and investments to at risk populations
- Use outcomes to evaluate the degree of change attributed to interventions
- Develop forums to share promising practices
- Leverage eHealth strategies

OBJECTIVES

What it could look like

Over the next one to two years...

- Explore opportunities for additional funding
- Improve access to diabetes care through primary care
- Prioritize areas for new programs/services especially community based ones with a focus on prevention
- Engage the public Family Health Teams and other primary care providers in the identified geographic areas
- Foster joint planning through improving linkages with other ministries such as Ministry of Community and Social Services, Ministry of Child and Youth Services and other agencies as appropriate
- Engage primary care, public health and other stakeholders regarding population health status and explore opportunities to share best practices and promote knowledge transfer

Over the next three years...

- Increase availability of programs and services to meet the needs of the population with approved resources

Some inspiration from the perspective of our IHSP 2010-2013 Citizen's Panel. What could be...

Imelda is a young refugee living in the Jane-Finch area of North York, with her two young children aged three and 10. She and her children currently live at a shelter while she works during the evenings. One night, Imelda arrives home to find her 10 year old daughter feeling very ill. After arriving at the hospital, her child is admitted and kept overnight for tests and observation. The doctors tell Imelda that her daughter is suffering from diabetes. They refer her to the nearest diabetes team, which is located in a clinic not far from the shelter. Over the next few weeks, the team teaches Imelda and her daughter all about diabetes, the importance of diet and other ways to help them manage the disease.

7

Rationale for Strategic Directions

How we chose our planning priorities...

Central LHIN identified its four planning priorities, and developed actions plans for each, based on evidence from province-wide and LHIN-specific health indicators, our Health Service Needs Assessment and Gap Analysis project, alignment with the priorities of the Ministry of Health and Long-Term Care, and extensive engagement with local communities and health care providers.

By definition, prioritizing means choosing between options. Once we determined a list of potential priorities, our method for selecting our planning priorities involved evaluating, weighting and ranking potential priorities by asking *"Does this priority...:*

- match our Health Service Needs Assessment and Gap Analysis data, and align with Ministry of Health and Long-Term Care priorities?
- focus on improving the health care system by linking to our four capability areas?
- improve sustainability and / or reduce cost?
- have measurable and implementable outcomes?

Priorities with lower rankings were not selected for inclusion in this IHSP 2010-2013, but may be considered in future planning activities. Although we have developed clear priorities it does not means that areas not specifically targeted are not important or will not be addressed in some ways. Our IHSP 2010-2013 is about reprioritizing and refocusing. By continually assessing and evaluating our IHSP, engaging with stakeholders and the community and monitoring trends, we will continue to respond to local needs.

Overall, the planning priorities we chose are linked to our outcome map, and directly support improvements in our four capability areas to achieve our vision of caring communities, healthier people, and health system sustainability. This chapter briefly outlines some further detail around the rationale supporting each of our planning priorities.

Priority: Emergency Department and Alternate Level of Care

Whether or not you require urgent care, the time spent in emergency departments can be lengthy. And while 90% of emergency department patients are seen, treated and discharged within 9.4 hours, that wait time jumps five times longer – to about 35 hours – for emergency department patients that need to be admitted. In fact, on average 75% - or 26 hours – of that time is spent waiting for an in-patient bed.

That's just one reason why reducing emergency department wait times and the time people spend in acute care beds while waiting for more appropriate care placement is both a Central LHIN and a Ministry of Health and Long-Term Care priority.

In the fiscal year 2008-2009:

- In Central LHIN, the average percent of days patients spent in acute care settings waiting for alternate levels of care was 13.06%, compared to our target of 9.6%.

  The provincial alternate level of care percentage is 15.46% with a provincial target of 9.46%.

- The median time patients waited for placement into long-term care facilities was 94 days, compared to our target of 55 days.

  The provincial median wait time for long-term care placement was 104 days, compared to the provincial target of 50 days.

- In Central LHIN, the percentage of admitted patients in the emergency department with a length of stay within eight hours was 24% compared to the province at 39%.

- The proportion of non-admitted high acuity patients treated within the provincial target of eight hours for high acuity and six hours for medium level acuity is 77%, compared to the provincial rate of 82%.

- The proportion of non-admitted low acuity patients treated within the provincial target of four hours is 86%, compared to the provincial rate of 85%.

Central LHIN's population is both growing and aging. We are one of the fastest growing LHINs in the province. In addition, while today the number of our seniors over 65 is 204,145. In 10 years that number is projected to be 285,555 – an increase of 40%. The number of our seniors over 85 is 24,342, and in 10 years that number is projected to be 34,883 – an increase of 43%. This translates into an increase in demand for services across the care continuum. It also means we need to focus on this priority in particular as we know that seniors make up 88% of the people in an alternate level of care bed waiting for placement in a more appropriate care setting.

Other challenges within the health care system complicate this issue. For example, many of our residents face barriers to accessing primary care, such as a family doctor or a walk-in clinic. This often results in individuals inappropriately seeking care through the emergency department.

We also know that our LHIN doesn't have enough long-term care beds to meet current demand. Currently, Central LHIN has fewer long-term care beds compared to the province as a whole. Our per capita rate for the 6,979 long stay beds is 287 per 1,000 (85+) compared to the provincial average of 338 bed per 1,000 (85+). Central LHIN also has a low rate of complex continuing care beds – two per 10,000 population compared to the provincial rate of 11.0 per 10,000 population.

Over the next three years and beyond, meeting demand for emergency services and improving the alternate level of care situation will be only be addressed through shared problem solving across the sectors. Central LHIN has committed to achieving improvements across our planning areas and target groups through the Emergency Department Pay for Results program as well as the Aging at Home strategy.

Priority: Chronic Disease Management and Prevention

In Central LHIN, those seeking help for chronic diseases account for 25% of in-patient hospital cases, 10% of emergency department visits and 20% of family physician visits. The World Health Organization estimates that Canada incurs $89 billion annually in direct and indirect costs related to chronic diseases. Central LHIN's share of this financial burden is estimated at $4.1 billion annually.

Over time these costs will grow as our population ages and the incidence of chronic disease increases. Within 10 years, our population aged 65 and over will grow by 40%, giving us the largest population of seniors in Ontario and potentially the largest concentration of chronic disease.

There are several other evidence-based reasons for making chronic disease management and prevention a priority in our LHIN. First, people who live in lower socioeconomic conditions have higher rates of chronic disease. We have identified at risk populations in two of our planning areas that have both a higher than average prevalence of diabetes, and a higher forecasted number of people with diabetes.

Second, 75% of patients with diabetes receive treatment only from their primary care physician. Yet, across Central LHIN's planning areas, access to primary care is limited.

Third, by focusing on chronic disease management and prevention, we have a tremendous opportunity to contribute to the health of our population and control health care costs. There is evidence that, 90% of diabetes cases can be prevented by following modestly healthier lifestyles incorporating, for example, physical activity, healthy eating, not smoking and limiting alcohol use.

Even moderate gains in better managing chronic disease will decrease this significant driver of demand for health care services in the future. A 2007 Ontario Health Quality Council report estimated that preventing just 33% of new cases of diabetes will save $70 million in health care costs in the first year.

Priority: Mental Health and Addictions

Mental illness and addictions affects people of all ages, cultures and backgrounds. According to a 2008 report by the National Institute of Mental Health, mental health disorders are the leading cause of disability in Canada for people aged 15 to 44.

At least 214,562 LHIN residents are living with mental illness and addiction issues and 23,071 people have a mental illness such as bipolar disorder or schizophrenia.

Many are not receiving the community mental health treatment and support they need. For example, just over 3,800 of our residents received substance abuse services while our data suggests there are over 100,000 individuals with substance abuse issues within our LHIN.

A major challenge the system needs to address is that people who present with mental health and addictions disorders don't always receive treatment for other underlying health conditions, which can worsen over time. Many people living with mental illness are at increased risk of premature death from chronic physical health problems such as stroke, cancer, heart disease and diabetes.

In fact, serious mental illness puts individuals at greater risk of mortality related to cardio-vascular conditions. Individuals with serious mental illness are also two–four times more likely to have diabetes. However, only 67–75% of these individuals are diagnosed with diabetes at early stages. This often results in under-treatment, increasing the risk of complications.

Additionally, within our LHIN, people often have long wait times for assessment and services. Addressing gaps in services and wait times can reduce the number of non-urgent cases treated by emergency departments.

Without appropriate treatment, evidence shows that people with mental health and addictions challenges use health care services more frequently than other consumers yet there is a gap between mental health patients and primary care providers. Therefore, they often access inappropriate levels of care – for example, going to emergency departments rather than to primary care providers or community-based programs that may be better able to provide the services they need.

Results from the Discharge Abstracts Database tell us that in 2008, 19,791 individuals were served through LHIN-funded community mental health and addictions services. Of that number, 10,231 individuals were seen in the emergency department and 3,961 were admitted into hospital. These numbers typically represent individuals with moderate to serious mental illness. Others with more mild mental illness are either treated by their family doctor, or never diagnosed or treated at all.

Mental health and addictions has been identified as a Ministry of Health and Long-Term Care priority, and Central LHIN will align its mental health and addictions strategy with that of the Ministry.

Priority: Health Equity

One of the most important principles of our public health system is equitable access to health care services. However, through our Health Service Needs Assessment and Gap Analysis (SNAGA) project, we identified two population groups within Central LHIN with significant obstacles to accessing care.

> "The Central LHIN will strive to reduce health disparities as a shared responsibility with its health service providers by integrating health equity into strategies and activities within its mandate and influence."
>
> Central LHIN statement of commitment for reducing health disparities

About 14.4% of Central LHIN's population lives in the North York West planning area. Compared to other planning areas, North York West – specifically, the Jane-Finch neighbourhood – has the second-highest percentage of residents over age 65. About half the population are visible minorities, and more than half speak a language other than English as their mother tongue.

The area also has the highest percentage of low-income families, single-parent families and people age 20 and over with less than a high school education. Research has shown that those living in poverty are more likely to smoke, abuse alcohol or drugs and report higher incidences of accidents and violence – all of which can have an impact on their health and ultimately the health care system.

At first glance, the isolated First Nations community on Georgina Island in our South Simcoe/Northern York Region planning area seems very different from the densely packed, urban North York West planning area – but it shares many of the same challenges. Georgina Island's population of just a few hundred people has the highest concentration of low-income families, single-parent families and people age 15 and over with less than a high school education.

Beyond the general health care concerns faced by many poorer communities, Georgina Island has two specific health challenges. Obesity is widespread throughout the community, and affects an estimated 75% of children. In addition, about one in four community members have diabetes – most commonly type II diabetes.

In both the South Simcoe/Northern York Region and the North York West and planning areas, efforts to improve health equity must consider language and culture, socio-economic conditions, family structure, education and other social factors.

Then, by using data and local knowledge to develop targeted health care programs, Central LHIN has a tremendous opportunity to reduce health inequities, increase people's ability to respond effectively to health care challenges and make a positive difference to population health.

Our 2008 Health Service Needs Assessment and Gap Analysis provides detailed information on the health of Central LHIN residents. Read the full report at www.centrallhin.on.ca

8

How Success will be Demonstrated and Measured

How we'll know when we get there...

It has been said that what gets measured gets managed. Central LHIN's IHSP 2010-2013 sets clear, measurable goals, that can be monitored in order to track our progress in achieving our outcomes, and refine our action plans as necessary.

Over time, Central LHIN will measure success by:

- linking our outcomes to measurable targets and indicators that are based on Ministry-LHIN Accountability Agreement targets,
- regular performance monitoring, and
- working with providers to collaborate to address system challenges.

As mentioned in the planning framework chapter, accountability agreements with our health service providers across the sectors will be key to our success over the next three years. These agreements help to clearly define expectations of both the LHIN and its health service providers, and help us each be accountable for our role in achieving our IHSP 2010-2013 priorities.

The following tables briefly illustrate how we will measure our success in achieving the goals within each of our planning priorities. Targets are measurable outcomes that we are aiming for, while indicators will be used to measure our progress.

Emergency Department and Alternate Level of Care

INDICATORS **What we will measure**	TARGETS **What target we will try to meet**
• Rate of ambulatory care sensitive conditions • Rate of emergency department visits that could have been managed elsewhere • Rate of unscheduled visits/1000 population MLAA targets: • Proportion of admitted patients admitted within eight hours • Proportion of non admitted CTAS I&II patients treated within MLAA timeframes • Proportion non admitted CTAS III patients treated within MLAA timeframes • Proportion of non admitted CTAS IV &V patients treated within MLAA timeframes • Percent alternate level of care days as per MLAA measures • Median wait time to long-term care home placement as per MLAA agreement • Patient satisfaction with health service provider emergency department services	Over the next three years we will strive to meet MLAA targets as listed (note: these targets may change per Ministry): • 10 percent absolute improvement in the proportion of admitted patients admitted within eight hours • 10 percent absolute improvement in the proportion of non-admitted CTAS I-II patients treated within eight hours • 10 percent absolute improvement in the proportion of non admitted CTAS III patients treated within six hours • 10 percent absolute improvement in the proportion of non-admitted CTAS IV-V patients treated within four hours • Alternate level of care days no greater than 9.5% • Median wait time to long-term care home placement no greater than 61 days • Improvement in emergency department patient satisfaction scores

Chronic Disease Management and Prevention

INDICATORS

What we will measure

- MLAA indicators for diabetes to be determined
- Rate of ambulatory care sensitive conditions for identified chronic disease groups
- Rate of emergency department visits that could have been managed elsewhere as per above
- Other indicators to be developed

TARGETS

What target we will try to meet

Over the next three years we will strive to:

- Meet MLAA targets for diabetes as determined by Ministry
- Maintain or reduce rate of ambulatory care sensitive conditions for identified chronic disease groups.
- Maintain or reduce rate of emergency department visits that could have been managed elsewhere as per above
- Other targets to be developed

Mental Health and Addictions

INDICATORS

What we will measure

- MLAA indicators for mental health and addictions to be determined
- Rate of ambulatory care sensitive conditions for mental health and addictions
- Rate of emergency department visits that could have been managed elsewhere as per above
- Management information system compliance and reporting

TARGETS

What target we will try to meet

Over the next three years we will strive to:

- Meet MLAA targets related to mental heath and addictions as determined
- Maintain or reduce rate of ambulatory care sensitive conditions for mental health and addictions
- Maintain or reduce the rate of emergency department visits that could have been managed elsewhere as per above
- Improved management information system compliance and reporting

Health Equity

INDICATORS

What we will measure

- Compliance with French Language Services engagement plan when developed by the Ministry
- Compliance with the Aboriginal community engagement plan as developed by the Ministry
- Population health indicators
- Additional indicators to be developed

TARGETS

What target we will try to meet

Over the next three years we will strive to:

- Develop specific indicators and targets
- Meet or exceed French Language Services engagement plan targets, timelines
- Meet or exceed Aboriginal engagement plan targets, timelines
- Review monitor, analyze and disseminate population health indicators annually

Putting it all Together

Achieving the targets within each of our priority action plans will require Central LHIN to partner effectively with key stakeholders, including other LHINs (particularly in the Greater Toronto Area), health service providers, the Ministry of Health and Long-Term Care, municipalities, and others.

We will need to align our efforts with related projects undertaken by, for example, primary care providers, Emergency Medical Services and non-governmental organizations such as the United Way, the Alzheimer's Society, and the Ontario Chronic Disease Prevention Alliance. Though these areas are out of scope for the LHINs, we hope our efforts will also contribute to initiatives focused on improving public health and other determinants of health.

We must also coordinate all our priorities. All will play an integrated role in reducing wait times for emergency health care services and improving the access and coordination of community-based services. Those community-based services, for their part, will be increasingly important as the health care system evolves to provide more services outside acute care facilities.

Finally, focused measurement will help us to see where our region is achieving good results in improving health care. This will allow us to share and celebrate successes with our health service providers and our communities, and together build upon our achievements.

Our Ministry-LHIN Accountability Agreement (MLAA) – available at www.centrallhin.on.ca – defines our relationship with the Ministry of Health and Long-Term Care, and outlines performance indicators we will strive to meet.

9

Supporting Documents

Laying the foundation of our IHSP 2010-2013 . . .

The planning priorities of Central LHIN's Integrated Health Service Plan 2010-2013 are based in large part on the information we learned through our comprehensive 2008 Health Service Needs Assessment and Gap Analysis project.

Through this initiative, Central LHIN gained valuable insight into the health care challenges and opportunities in our LHIN, including the specific concerns of our Aboriginal and French-language communities.

The findings of the final report were shaped by two main components: statistical data about our LHIN, such as the average age, gender, and health of our population, and input from extensive stakeholder engagement.

The project was initiated to assist us to identify the long-term health service needs in Central LHIN, the types of health services we are able to deliver today and the types of health services we need to be able to deliver in the future.

What we learned guided our planning at a local level, and helped us to identify four areas where we saw potential to have a positive impact in our communities.

The complete 2008 Health Service Needs Assessment and Gap Analysis report, including its many targeted and informative appendices, is available for download from the Central LHIN website at www.centrallhin.on.ca.

Of interest in relation to our IHSP 2010-2013 planning priorities

These specific sections and appendices of the Health Service Needs Assessment and Gap Analysis project final report relate directly to our four IHSP 2010-2013 planning priorities:

- Emergency Department and Alternate Level of Care
  Appendix L: Emergency Services Domain Deck
- Mental Health and Addictions
  Appendix M: Mental Health and Addictions Domain Deck
- Chronic Disease Management and Prevention
  Appendix K: Chronic Disease Domain Deck
- Health Equity
  Central LHIN Planning Area Profiles

Definitions

An explanation of some of the terms used in our Integrated Health Service Plan 2010-2013...

Alternate Level of Care: A designation given to individuals who are occupying acute care beds in hospitals that could be more appropriately cared for in another setting such as a long-term care home, rehabilitation hospital, or home.

Annual Service Plan: A component of the Ministry of Health and Long-Term Care/Local Health Integration Network Accountability framework that operationalizes the LHIN's Integrated Health Services Plan by providing goals and objectives for spending the year's funding allocation.

Community Care Access Centre: Local organizations established by the Ministry of Health and Long-Term Care to provide access to government-funded home and community services and long-term care homes. Community Care Access Centres also provide information about local community support service agencies and can link people to these agencies to arrange services.

Community Health Centre: Non-profit organizations that provide primary health care and health promotion programs for individuals, families and communities.

Connecting GTA: a five-LHIN collaborative project designed to support clinical information exchange such as lab results and drug information, among health care providers in the greater Toronto area.

Health Equity: A strategy that aims to reduce disparities in health among diverse population groups. Health equity strategies involve creating more equitable access to health services, consistent high quality care, and an equitable distribution of health resources, among others.

Hospital Discharge Abstracts Database: A provincial database that contains demographic, administrative and clinical data for relating to hospital discharges from inpatient beds (acute, chronic, rehabilitation) and day surgeries.

Doorways to Care: An enhanced telephone-based program that helps seniors connect with local community-care organizations.

Family Health Team: An approach to primary health care that brings together doctors, nurses, nurse practitioners and other health care professionals to work collaboratively to co-ordinate and delivery health care to a group or roster of patients.

Health Service Providers: The collective term for hospitals, community care access centres, long-term care homes, community support service agencies, and mental health and addiction agencies.

Integration: An activity that involves coordinating, partnering, transferring, merging or amalgamating services or business operations.

Local Health Integration Network: The not-for-profit organizations that work with local health providers and community members to determine the local health service priorities of their regions. They were created in April 2006, and took on their full role of planning and funding health services April 1, 2007.

Local Health System Integration Act, 2006: The Ontario legislation that governs the activities of Local Health Integration Networks.

Ministry-LHIN Accountability Agreement: The formal agreement between the LHINs and the Ministry of Health and Long-Term Care that defines the roles and responsibilities of each of the parties.

Resource Matching and Referral: an electronic referral system designed to improve client/patient transitions between levels of care (for example, between hospital acute care and long-term care).

Social Determinants of Health: The economic, social and physical environmental conditions that impact the health status and health service needs of the population.

Appendices

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Additional Resources

The following information was valuable to inform Central LHIN as we developed our Integrated Health Service Plan 2010-2013…

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AT A GLANCE: Emergency Department and Alternate Level of Care Priority

CURRENT STATE (Where We Are)

Reducing time spent in the emergency department waiting for care is a complex issue that has become both a provincial priority, and a Central LHIN planning priority. Because moving people through the emergency department depends in part on the ability to either admit patients to acute care beds, or to discharge patients to appropriate destinations, reducing wait times can't be solved by focusing on the emergency department alone. Central LHIN's emergency department/alternate level of care strategy recognizes that system improvements are necessary to ensure people receive prompt emergency care and that appropriate alternatives to hospital care exist in the community.

FUTURE STATE (Where We Want To Go)

- Reduced numbers of non-urgent cases that present at the emergency department will enable emergency clinicians to focus on patients with higher acuity
- Improved triage and admission processes will enable more efficient emergency care
- Communities will experience an increase in access, coordination and integration of health services

Goals (What We Want To Do)	Objectives (What It Could Look Like)	Indicators (What We Will Measure)	Targets (What Target We Will Try To Meet)
• Reduce demand on emergency department services	• Reduce emergency department visits by targeted groups • Reduce unplanned re-admission rate to the emergency department	• Rate of ambulatory care sensitive conditions • Rate of emergency department visits that could have been managed elsewhere • Rate of unscheduled visits/1000 population	• Maintain or reduce rate of ambulatory care sensitive conditions • Maintain or reduce rate of emergency department visits that could have been managed elsewhere • Maintain or reduce rate of unscheduled visits/1000 population
• Increase capacity and improve emergency department performance	• Reduce emergency department wait times to achieve targets identified for admitted patients, non-admitted high acuity patients, and non-admitted low acuity patients • Reduce % alternate level of care days in hospital • Review existing baseline data on patient satisfaction	• Proportion of admitted patients admitted within eight hours • Proportion of non-admitted CTAS I&II treated within MLAA timeframes • Proportion non-admitted CTAS III treated within MLAA timeframes • Proportion of non-admitted CTAS IV & V treated within MLAA timeframes • Patient satisfaction with health service providers emergency department services	Meet MLAA targets: • 10% absolute improvement in proportion of admitted patients admitted within eight hours • 10% absolute improvement in proportion of non-admitted CTAS I & II patients treated within eight hours • 10% absolute improvement in proportion of non-admitted CTAS III patients treated within six hours • 10% absolute improvement in proportion of non-admitted CTAS IV & V patients treated within four hours • Improvement in emergency department patient satisfaction scores
• Reduce length of stay in alternate level of care to improve access to hospital	• Reduce delays in placement to appropriate level of care and settings	• Percent alternate level of care days as per MLAA measures • Median wait time to long-term care home placement as per MLAA agreement	Meet MLAA targets: • Percent alternate level of care days no greater than 9.5% or as per MLAA agreement • Median wait time to long-term care home placement no greater than 61 days or as per MLAA agreement

ENABLERS

• eHealth • Effective Communications Strategy • Primary Care • Health Human Resources

For additional details please refer to our IHSP 2010-2013.

AT A GLANCE: Chronic Disease Management and Prevention Priority

CURRENT STATE (Where We Are)

Chronic diseases, such as diabetes, congestive heart failure, arthritis and stroke have significant personal, social and economic impacts. The treatment of chronic diseases and their complications places significant demand on our acute care system and community-based services – a demand that is expected to increase with the aging of the population. Central LHIN's chronic disease management and prevention strategy focuses on streamlining the delivery system and putting a comprehensive plan in place to support self-management. It aligns with the Ministry of Health and Long-Term Care's Chronic Disease Prevention and Management Framework.

FUTURE STATE (Where We Want To Go)

- Enhanced continuity of care improved system design, processes and patient outcomes
- Improved self management supports allowing patients to maintain their health status and delay the need for acute hospital services
- Targeted primary and secondary prevention programs that will delay the onset of complications and reduce the burden on the health care system overall
- Improved partnerships with the Ministry of Health and Long-Term Care's Ontario Diabetes Strategy with increased access to multidisciplinary care for people with diabetes to better treat and manage their condition

Goals (What We Want To Do)	Objectives (What It Could Look Like)	Indicators (What We Will Measure)	Targets (What Target We Will Try To Meet)
• Support the MOHLTC Diabetes Strategy • Collaborate with the Ontario Renal Network	• Support the implementation of local activities of the strategy as per MOHLTC • Collaborate with the Ontario Renal Network to enhance access to dialysis services	• To be developed as per MOHLTC strategy	• Meet MLAA targets as developed by the MOHLTC
• Enhance self-management supports for chronic disease	• Reduce avoidable emergency department visits and unplanned readmission for targeted populations	• Rate of ambulatory care sensitive conditions for identified chronic disease groups • Rate of emergency department visits that could have been managed elsewhere as per above	• Maintain or reduce rate of ambulatory care sensitive conditions for identified chronic disease groups • Maintain or reduce rate of emergency department visits that could have been managed elsewhere as per above
• Improve primary and secondary prevention of chronic disease	• Support the work of the Chronic Disease Management and Prevention Advisory Network to identify, disseminate and support adoption of best practices in primary/secondary prevention services	• To be developed	• To be developed

ENABLERS

• Health Human Resources • Primary Care • eHealth • Decision Support

For additional details please refer to our IHSP 2010-2013.

AT A GLANCE: Mental Health and Addictions Priority

CURRENT STATE (Where We Are)

People with mental health and addictions conditions have difficulty accessing care due to demands that far exceed available resources. Data suggests more than 100,000 individuals in Central LHIN experience substance abuse, however just over 3,800 received addiction treatment. By continuing to make mental health and addictions a priority in Central LHIN, we can focus resources to coordinate care and bridge gaps in the system, reduce wait times for assessment and services, and enhance community supports. Our mental health and addictions strategy aligns with the Ministry of Health and Long-Term Care's model for mental health and addictions service delivery.

FUTURE STATE (Where We Want To Go)

- Improved community-based services that reduce the number of non-urgent cases that present at the emergency department and enable emergency clinicians to focus on patients with critical needs
- Improved linkages amongst health service providers can improve access to the appropriate level of service and improve access to information
- Targeting marginalized groups and providing information about healthcare options, services will support those in need
- Identifying populations at risk and addressing service gaps can improve the overall health of those with mental health and addictions conditions

Goals (What We Want To Do)	Objectives (What It Could Look Like)	Indicators (What We Will Measure)	Targets (What Target We Will Try To Meet)
• Support the MOHLTC Mental Health and Addictions Strategy	• Support the implementation of local activities as per the MOHLTC Mental Health and Addictions Strategy	• To be developed as per MOHLTC strategy	• Meet MLAA targets as developed by MOHLTC
• Reduce gaps in service and improve linkages across the continuum of care	• Support initiatives that streamline access to care • Improve access to supportive housing and related services	• To be developed	• To be developed
• Target mental health and addictions needs that impact access to emergency department and hospital services	• Expand community-based mental health services as alternatives to the emergency department	• Rate of ambulatory care sensitive conditions for mental health and addictions • Rate of emergency department visits that could have been managed elsewhere as per above	• Maintain or reduce rate of ambulatory care sensitive conditions for mental health and addictions • Maintain or reduce the rate of emergency department visits that could have been managed elsewhere
• Promote awareness of diversity needs	• Continued engagement with those with lived experiences and their families	• To be developed	• To be developed
• Improve the data quality, and analysis in the mental health and addictions sector	• Improve understanding of current state and challenges facing data quality within the sector	• Management Information system compliance and reporting	• Improved data consistency

ENABLERS

• **Health Human Resources** • **Primary Care** • **eHealth** • **Decision Support**

For additional details please refer to our IHSP 2010-2013.

AT A GLANCE: Health Equity Priority

CURRENT STATE (Where We Are)

Central LHIN's health equity priority aims to reduce health disparities within targeted population groups in the South Simcoe/Northern York Region and North York West planning areas. These areas have been identified as having higher than average incidence of serious health conditions and inadequate access to primary care. There is a high rate of emergency department use due, in part, to limited access to alternative resources. Our equity strategy is based on the Ministry of Health and Long-Term Care's Population Health Framework and will focus on working with our health service providers and the communities to expand services where possible.

FUTURE STATE (Where We Want To Go)

- More equitable access to care will enable to people get the right service at the right time in the right setting by the right health service provider. It will ultimately result in a healthier population overall.
- Improved access to primary care will reduce the number of non-urgent cases that present at the emergency department enabling emergency clinicians to focus on patients with critical needs
- Increased outreach and community engagement will bring services to people who are not currently receiving them.

Goals (What We Want To Do)	Objectives (What It Could Look Like)	Indicators (What We Will Measure)	Targets (What Target We Will Try To Meet)
• Target investments in health care services in identified geographic areas to address health service inequities • Improve access to diabetes care and primary care in these areas	• Explore opportunities for additional funding • Increase availability of programs and services to meet the needs of the population with approved resources • Improve access to diabetes care through primary care • Prioritize areas for new programs/services especially community-based ones with a focus on prevention	• To be developed	• To be developed
• Engage the public and improve collaboration across sectors • Identify and support Aboriginal engagement strategy • Support French Language Services engagement strategy	• Ongoing engagement with the public in the identified geographic areas and populations • Engage Family Health Teams and other primary care providers • Foster joint planning through improving linkages with other ministries such as, Ministry of Community and Social Services, Ministry of Child and Youth Services and other agencies as appropriate (i.e. First Nations and Inuit Health Branch)	• As per French Language Services Engagement Plan as developed by the MOHLTC • As per Aboriginal engagement plan as developed by the MOHLTC	• As per French Language Services Engagement Plan as developed by the MOHLTC • As per Aboriginal engagement plan as developed by the MOHLTC
• Monitor the health status indicators in the identified geographic areas	• Engage primary care, public health and other stakeholders regarding population health status and explore opportunities to share best practices and promote knowledge transfer	• Population health indicators	• Review, monitor, analyze and disseminate population health indicators annually

ENABLERS

• **Health Human Resources** • **eHealth** • **Primary Care** • **Decision Support**

For additional details please refer to our IHSP 2010 -2013 .

Central LHIN eHealth Action Plan

The Central Local Health Integration Network (LHIN) is well aligned to the provincial eHealth strategy, and has identified four key eHealth priorities that focus on the need to integrate clinical information across the continuum of care. Specifically, Central LHIN – in collaboration with the other Greater Toronto Area LHINs – aims to:

- **Improve the care process** – through initiatives such as the Resource Matching and Referral program,
- **Improve the exchange of information across the health system** – through initiatives like ConnectingGTA (formerly Health Integration Access Layer and Provider Portal),
- **Support patient/client participation in their own health care** – using technology such as the patient portal, and
- **Support provincial eHealth initiatives** – like the Diabetes Registry, Ontario Lab Information System, Drug Information System, and the Wait Time Information System.

These eHealth initiatives support the priorities outlined in Central LHIN's Integrated Health Services Plan 2010-2013, in particular as they relate to addressing emergency department and alternate level of care issues and supporting chronic disease management models that are being developed. Other health-service provider eHealth initiatives – such as the Data Centre Consolidation Project – are foundational and will support the LHIN's capacity to participate in regional and provincial initiatives by ensuring that the appropriate and sustainable infrastructure is in place.

Further to the planning and implementation of the initiatives outlined, the LHIN will continue to strengthen the framework and oversight within which the implementation and adoption of these solutions will be successful and sustainable. This includes, but is not limited to, the appropriate and ongoing engagement of health service providers within the LHIN and collaborating with other LHINs.

For each initiative Central LHIN will explore opportunities to leverage principle funding and resources.

Initiative	2009-2010	2010-2011	2011-2012	2012-2013
Resource Matching and Referral	• Working with other LHINs, initiate project mobilization, including establishment of project team and development of a communication plan. • Understand current state of referral processes for the pathways defined in the provincial reference model. • Identify high-level future state considerations for the same pathways. • Development of a business case that articulates the need for resource matching and referral to support health system transformation, particularly in the context of emergency department and alternate level of care and gaining process efficiencies.	• Validate and refine future state considerations for the in-scope referral pathways; develop detailed business and technical requirements in preparation for solution procurement. • Complete regional resource matching and referral solution procurement in alignment with the provincial reference model. • Initiate resource matching and referral implementation.*	• Continue implementation of regional resource matching and referral solution of in-scope referral pathways in alignment with provincial plans.*	• Continue implementation of regional resource matching and referral solution for in-scope referral pathways in alignment with provincial plans.*
ConnectingGTA	• Initiate implementation phase including formalization of memorandum of understanding for regional program oversight, establishing program office functions and procurement of solution components. • Commence regional stakeholder engagement including increasing number of sites connected to Ontario Lab Information System (OLIS).	• Continue implementation of connectingGTA program including portal, health integration access layer development and implementation of Ontario Lab Information System and drug profile viewer "portal gadgets" to view information in connectingGTA portal.	• Pending funding approval, continue implementation of connectingGTA. program in alignment with eHealth office and regional priorities.	• Continue implementation of connectingGTA program including development and implementation of a regional clinical data repository to support integration with legacy clinical systems. • Secure ongoing funding approval for future implementation phase beyond initial three-year scope.

* pending availability of resources and requisite approval

Central LHIN eHealth Action Plan continues on the next page...

Central LHIN eHealth Action Plan (continued)

Initiative	2009-2010	2010-2011	2011-2012	2012-2013
Regional Diagnostic Imaging Repositories: • GTA West Diagnostic Imaging Repository	• Complete procurement of vendor consortium to support regional diagnostic imaging repository. Formalize regional program governance and establish program office functions. Participating hospitals to sign-off on participation agreement with transfer payment agencies (of Central LHIN's six acute care hospitals, one is participating in this initiative, the other five are engaged in the Hospital Diagnostic Imaging Repository Services initiative listed below).	• Develop and implement regional diagnostic imaging repository with early adopter sites. • Implement approved picture archiving and communication systems "Greenfield sites" including integration with regional diagnostic imaging repository. • Establish regional operational support model for diagnostic imaging repository participating sites.	• Pending funding approval, conduct integration planning with connectingGTA. • Implement integration with connectingGTA to make picture archiving and communication systems available regionally.	• Continue implementation of regional diagnostic imaging repository with remaining sites. • Continue implementation of remaining picture archiving and communication systems Greenfield sites.
Regional Diagnostic Imaging Repositories: • Hospital Diagnostic Imaging Repository Services	• Continue with current implementation by adding 35 hospitals to the diagnostic imaging repository (of Central LHIN's six acute care hospitals, five are participating in this initiative, the remaining one is engaged in the GTA West initiative listed above). • Develop three-year hospital diagnostic imaging repository service corporate strategic /tactical plan based on key stakeholder engagement.	• Complete implementation of 35 additional hospitals to diagnostic imaging repository. • Identify and address outstanding implementations necessary.	• Anticipating full incorporation of private diagnostic imaging exams and results, pending provincial direction.	• Ontario hospitals sharing diagnostic imaging images results with one another.
Patient Portal	• Support alignment between health service provider-driven innovation with respect to patient portal and regional integration initiatives, such as connectingGTA.	• Continue to support alignment between health service provider-driven innovation with respect to patient portal and regional integration initiatives, such as connectingGTA.	• Pending funding approval and direction from eHealth Ontario, initiate pre-implementation planning for patient portal pilot in Central LHIN.	• Pending funding approval and success of pilot, continue implementation of patient portal in Central LHIN. • Seek alignment with upcoming provincial strategy for patient portal solutions.
Diabetes Registry	• Support alignment of Central LHIN chronic disease management and prevention framework with provincial eHealth solution requirements and ultimate solution selection.	• Continue to support alignment of Central LHIN chronic disease management and prevention framework with provincial eHealth solution requirements and ultimate solution selection. • Pending provincial roll-out plans, conduct pre-implementation planning for provincial diabetes registry pilot.	• Pending funding approval, conduct integration planning with connectingGTA. • Implement integration with connectingGTA to support chronic disease management with connectingGTA-enabled clinicians. • In coordination with provincial roll-out plans, initiate implementation of diabetes registry pilot in the Central LHIN.	• Continue implementation of diabetes registry components in alignment with provincial roll-out plans.

Duclos Point
Port Bolster
Franklin Beach
Jacksons Point
Island Grove
Sutton
Virginia
Pefferlaw
Georgina
Roches Point
Baldwin
Udora
Keswick
Brown Hill
Ravenshoe
Glencairn
Lisle
SIMCOE
Everett
Nicolston
Alliston
Newton-Robinson
Rosemont
Bradford
Queensville
Mount Albert
Holland Landing
Holt
Sharon
Beeton
Bond Head
Newmarket
Pleasantville
Ballantrae
Loretto
Dunkerron
Wesley Corners
Musselman's Lake
Hockley
Colgan
Tottenham
Schomberg
Kettleby
Aurora
Vandorf
Preston Lake
Stouffville
Lloydtown
Pottageville
Snowball
Ringwood
YORK
Wilcox Lake
Gormley
King City
Oak Ridges
Nobleton
Elgin Mills
Markham
Richmond Hill
Buttonville
Maple
Richvale
Unionville
Kleinburg
Langstaff
Milliken
Thornhill
Concord
Woodbridge
TORONTO
Central Local Health Integration Network
Réseau local d'intégration des services de santé du Centre
Legend / Légende
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Communautés
LHIN Boundary
Limites des RLISS
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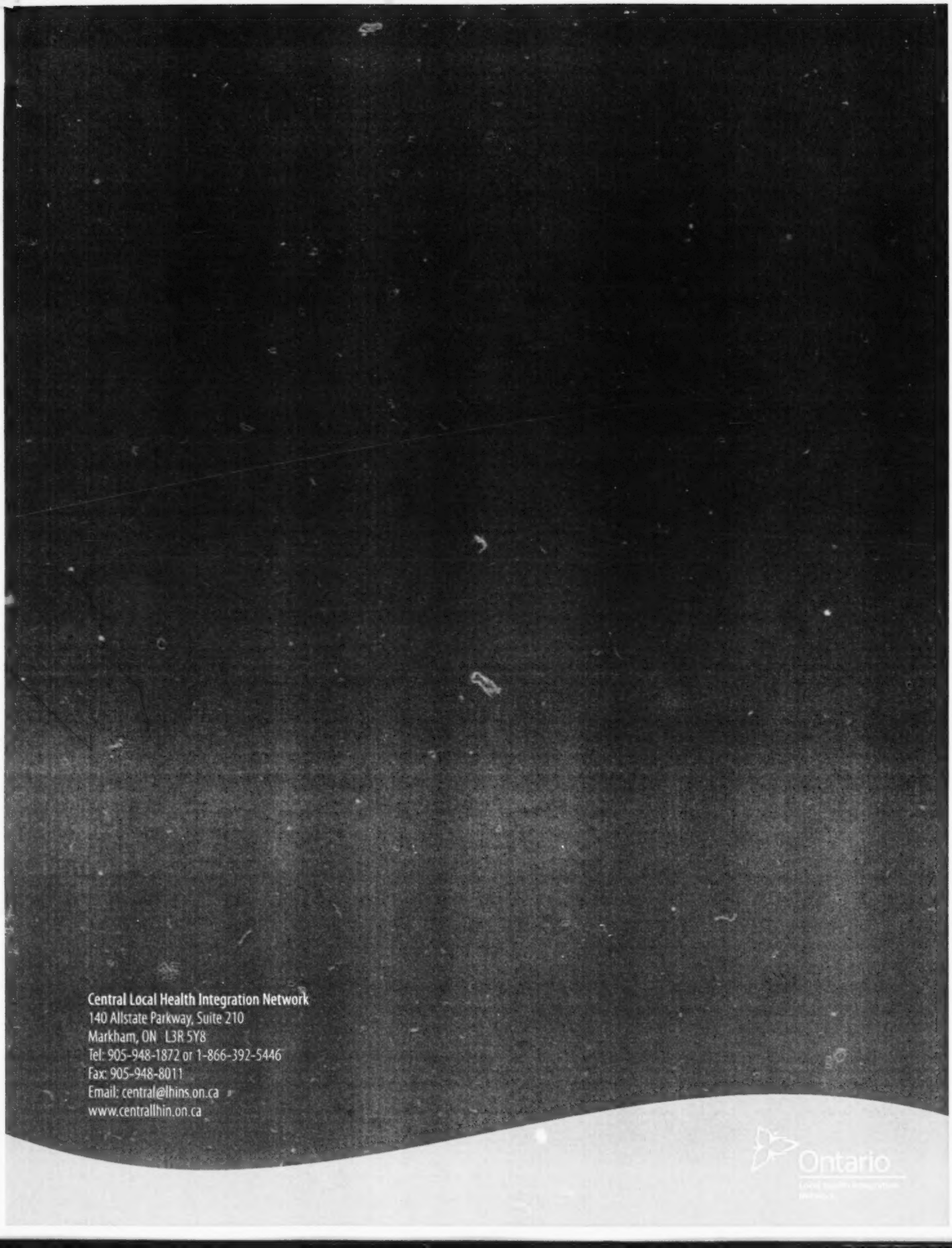

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